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NOMINATION

HEARING

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

HERBERT D. KLEBER, OF CONNECTICUT, TO BE DEPUTY DIRECTOR FOR DEMAND REDUCTION, OFFICE OF NATIONAL DRUG CONTROL POLICY

JULY 31, 1989

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NOMINATION

MONDAY, JULY 31, 1989

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:34 a.m., in room SD-430, Dirksen Senate Office Building, Hon. Edward M. Kennedy (chairman) presiding.

Present: Senators Kennedy, Pell, Simon, Hatch, and Thurmond.

The Chairman. We'll come to order.

Today we will consider the nomination of Herbert Kleber to be Deputy Director for the Demand Reduction of the Office of National Drug Control Policy.

His position is a key command post in the war on drugs. If the Nation loses the battle for demand reduction, we will also lose the war on drugs and significantly undermine our efforts in the battle against AIDS.

There is no army large enough to seal our borders against illegal drugs. We can never build enough prisons or put enough police on the beat to arrest or lock up all the drug peddlers.

Interdiction and law enforcement must be vigorous components of our national anti-drug effort. The modern merchants of death must never get a free ride. But we will never purge our society of the scourge of drug addiction without a strategy that places at least equal emphasis on prevention and treatment.

Prevention is the best and most cost-effective strategy. Well-designed prevention programs have a track record of success. In the past three years alone, the number of students who believe that casual use of cocaine is harmful has increased by 51 percent. As a direct result of that increase, the number of high school seniors using cocaine declined by 19 percent in 1987 and another 23 percent in 1988.

Well-designed local programs can achieve even deeper reductions. But the need is still overwhelming. According to surveys, 39 percent of high school seniors, more than one million students, used an illegal drug last year. A quarter of a million used cocaine. These levels are almost certainly higher among school dropouts.

In spite of these demonstrable successes, the Federal commitment to school-based prevention through the Drug-Free Schools program adds up to only one dollar per month per student. And too many of these programs fail to achieve their full potential because they are not designed to use the best available knowledge.

The Office of Substance Abuse Prevention in the Department of Health and Human Services is getting twice as many approved ap-

plications for community-based prevention programs as it can fund. It is time to give these prevention programs the priority they need and the funding that they deserve.

For millions of Americans, however, prevention is too late. According to the National Institute of Drug Abuse, 6.5 million citizens are deeply enough involved with drugs to require help to end their addiction.

Just as with prevention, there is solid evidence that treatment works. Drug addiction is a stubborn, chronic disease, but treatment is a cure for many, and it is highly cost-effective.

Studies show that treatment reduces drug use dramatically and that the gains are maintained for as long as 12 years. Similar reductions are found in crime and unemployment. Considering the reduction in crime alone, treatment is cost-effective.

Despite this proven effectiveness, the need for treatment far outstrips its availability. Today we spend only enough to provide treatment to 15 percent who are in need of it. Current backlogs cause unconscionable delays for those desperate to cure their addiction.

The Congress went on record on this issue in the 1989 drug bill, which set a goal of treatment on request, and it is time we provided adequate resources to reach that goal.

Dr. Herbert Kleber comes to the post of Deputy Director for Demand Reduction with a proven record of accomplishment. He is a Professor of Psychiatry at the Yale University School of Medicine, Director of the Substance Abuse Treatment Unit in the Connecticut Mental Health Center, and director of a respected treatment research center at Yale.

I hope that Dr. Kleber will be an effective advocate for prevention and treatment in our national drug policy. We had a good opportunity just prior to this meeting to review some of those programs that he is very familiar with in Kansas City and in Seattle, and also talk about some of the broader implications which really have not received the kind of focus and attention that the expansion and proliferation of drug abuse, particularly with regard to IV users, means in terms of the whole community as far as the health implications. Too often, we try and focus on this problem with sort of a single-shot approach, and I think we are very fortunate with Dr. Kleber, who understands in a very unique and special way, the importance of prevention, the importance of education, where he has been on the cutting edge, and also of treatment, and to bring his expertise and knowledge and awareness to the development of policy. So I think we are very, very fortunate indeed to have him.

So I might mention at the outset it is our intention, unless the committee feels otherwise, to move Dr. Kleber through the committee on Wednesday and hopefully have him in position before the Senate goes out this week. I know this is a very important high priority for the Administration and for all Americans, and that is the way we intend to proceed.

[Prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Today, we will consider the nomination of Dr. Herbert Kleber to be Deputy Director for Demand Reduction of the Office of National Drug Control Policy.

His position is a key command post in the war on drugs. If the nation loses the battle for demand reduction, we will also lose the war on drugs

There is no army large enough to seal our borders against illegal drugs. We can never build enough prisons or put enough police on the beat to arrest or lock up all the drug peddlers.

At a time when expenditures for law enforcement and interdiction have risen dramatically, the street price of cocaine has actually been dropping—indicating that more and more drugs are flooding into communities around America.

At a time when our prison population exceeds that of any other western country, every day brings new reports of clogged courts, over-saturated prisons, and rising drug-related crime.

Interdiction and law enforcement must be vigorous components of our national anti-drug effort. The modern merchants of death must never get a free ride. But we will never purge our society of the scourge of drug addiction without a strategy that places at least equal emphasis on prevention and treatment.

Prevention is the best and most cost-effective strategy. Well-designed prevention programs have a track record of success. In the past 3 years alone, the number of students who believe that casual use of cocaine is harmful has increased by 51 percent. As a direct result of that increase, the number of high school senior using cocaine declined by 19 percent in 1987 and another 23 percent in 1988.

Well-designed local programs can achieve even deeper reductions. The Kansas City school-community program showed a 46-percent decline in heavy marijuana use by junior high school students. A Seattle program for elementary school students showed that fifth graders with 4 years in the program were 23 percent less likely to use "gateway" drugs like cigarettes and alcohol.

But the need is still overwhelming. According to surveys, 39 percent of high school seniors, more than 1 million students, used an illegal drug last year. A quarter of a million used cocaine. These levels are almost certainly higher among school dropouts.

In spite of these deomonstrable successes, the Federal commitment to school-based prevention through the Drug-Free Schools program adds up to only a dollar per month per student. Too many of these programs fail to achieve their full potential because they are not designed to use the best available knowledge.

The Office of Substance Abuse Prevention in the Department of Health and Human Services is getting twice as many approved applications for community-based prevention programs as it can fund. The same is true of the youth gangs program and the runaway and homeless youth program.

It is time to give these prevention programs the priority they need and the funding they deserve.

For millions of Americans, however, prevention is too late. According to the National Institute for Drug Abuse, six and one half

million citizens are deeply enough involved with drugs to require help to end their addiction.

Just as with prevention, there is solid evidence that treatment works. Drug addiction is stubborn, chronic disease. But treatment is a cure for many, and it is highly cost-effective.

Studies show that treatment reduces drug use dramatically and that the gains are maintained for as long as 12 years. Similar reductions are found in crime and unemployment. Considering the reduction in crime alone, treatment is cost-effective.

Even for cocaine addicts, who currently have no alternative like methadone for heroin, treatment reduces drug use substantially. Finally, treatment is also effective in reducing the spread of AIDS among addicts and their sex partners.

Despite this proven effectiveness, the need for treatment far outstrips its availability. Today we spend only enough to provide treatment to 15 percent of those who need it. Current backlogs cause unconscionable delays for those desperate to cure their addiction.

The Congress went on record on this issue in the 1989 drug bill, which set a goal of treatment on request, and it's time we provided adequate resources to reach that goal.

Dr. Herbert Kleber comes to the post of Deputy Director for Demand Reduction with a proven record of accomplishment. He is Professor of Psychiatry at the Yale University School of Medicine, Director of the Substance Abuse Treatment Unit in the Connecticut Mental Health Center, and Director of a respected treatment research center at Yale.

I hope that Dr. Kleber will be an effective advocate for prevention and treatment in our national drug policy. I look forward to the opportunity to discuss his views today as we consider his nomination.

Senator Hatch. Thank you, Mr. Chairman. I appreciate that kind of dispatch with regard to handling Dr. Kleber's nomination.

I am pleased to support the nomination of Dr. Herbert Kleber as the Deputy Director for Demand Reduction. Dr. Kleber brings to this very important, newly-created position the experience and the talent necessary to help us in the battle against drug abuse. I applaud President Bush in this fine selection.

Dr. Kleber, I admire your willingness to join the ranks of those in public service. You have a broad and very difficult task ahead of you. Congress has suggested that you help to coordinate the thousands of Federal programs that work to reduce the demand for drugs through prevention, treatment and education.

Many people believe that those programs rest solely at the Department of Health and Human Services, the Department of Education, and the Department of Labor. And while those agencies do retain jurisdiction over the bulk of Federal demand reduction programs, there are others that we hope you will review. For example, we are spending $5 million to increase community-based volunteer programs through the ACTION agency. Also, the Veterans'' Administration and the Depart.nent of Defense have vast treatment and education programs.

These are just a few of the many examples showing the breadth of your mission. You are a highly-regarded expert, and I know that

you are going to be of great help to Dr. Bennett and to all of us in fighting our Nation's war on drugs.

I have found that one important indicator of success in Washington is the support and interest in a program that comes from beyond the Beltway. Every week, I hear people in Utah complain about the demand for drugs, and I hear from them about their activities, and plans and commitment to fighting this demand for drugs. For example, Utah's drug education program, entitled, K–12, has won national recognition for its ability to reach our State's youth and to teach them the harms of drug use and abuse.

There is a strong message from our mutual constituents. They are enlisted in the war on drugs, and they are ready, willing and able to assist you in your efforts in this very important position.

I have every confidence that you are the right person for this job. I support your nomination, and I as well as other members of this committee am eager to work with you, and I am heartened by the fact that the chairman of this committee is such a strong supporter. I think that bodes well for bipartisan support in this area, deserves bipartisan support and deserves having energetic and effective support of your work.

Also, having met with you in my office, having read a lot about you and, of course, having talked to various persons about you and your reputation and the experiences that you have had, I have to say that I think you really are the right person for this job. I look forward to working closely with you. You can count on us to help in any way we can.

Thank you, Mr. Chairman.

The Chairman. Thank you.

Senator Thurmond?

Senator THURMOND. Thank you, Mr. Chairman.

Mr. Chairman, I would like to commend you for conducting this hearing on the nomination of Dr. Herbert Kleber to be Deputy Director for Demand Reduction of the Office of National Drug Control Policy. I would also like to welcome Dr. Kleber to the committee.

I have had the opportunity to meet with Dr. Kleber and am confident that he will undertake his duties with enthusiasm and dedication.

Mr. Chairman, the Deputy Director for Demand Reduction has the responsibility of establishing policy, focusing on objectives, and setting priorities for the drug demand reduction activities of the new Executive-level Office of National Drug Control Policy.

The Deputy Director for Demand Reduction directs the Office of National Drug Control Policy in supporting initiatives to create drug-free workplaces, establish drug-free environments in the educational institutions of our Nation, expand substance abuse research and treatment efforts, as well as increase public awareness of the effects of substance abuse through outreach programs and publicity campaigns.

Additionally, the Deputy Director provides oversight and coordinates anti-drug policies of Federal departments and agencies, as well as heads demand reduction inter agency committees; serves as a liaison to other Executive Branch agencies, along with the education and social service communities, and the professional associa-

tions of our country; and directs Federal studies of national substance abuse programs. Mr. Chairman, these are important responsibilities which require the leadership abilities of an experienced professional in the field of substance abuse.

Dr. Kleber is well-qualified for this position. He received his undergraduate degree from Dartmouth College, his medical degree from the Thomas Jefferson Medical School, and performed his residency in psychiatry at the Yale University School of Medicine. He has served 2 years at the United States Public Health Service Hospital in Lexington, Kentucky, which has been the primary location for narcotic addiction treatment and research for many decades, and he founded the Drug Dependence Unit at Yale.

Dr. Kleber has established himself as a pioneer in the research and treatment of narcotic and cocaine abuse for the past 20 years. He is also the author or coauthor of over 160 papers on drug abuse.

Dr. Kleber is a well-respected leader in the medical profession and has proven himself to be an able administrator. I am pleased that our committee will have the benefit of receiving testimony today from him.

Mr. Chairman, it is most important that we direct our attention to the threat posed by drugs which permeates all levels of society in the United States. There has been increased awareness of the dangers of substance abuse in recent years, which has resulted in substantial increases in funding and the development of resources in these areas. The creation of the Office of National Drug Control Policy is a testament to the priority that is being placed, on the Federal level, to combating the war on drugs.

Mr. Chairman, much attention has been directed to the use of illegal drugs like cocaine and crack. The media reports daily on the toll that these drugs are taking on Americans, especially our youth. However, recent statistics show that there is a substance that is abused to an even greater extent than illegal drugs. That substance is alcohol.

Alcoholism and alcohol abuse are recognized as one of the most serious problems facing our Nation. Among teenagers, alcohol abuse has reached epidemic proportions. The Department of Health and Human Services estimates that 30 percent, or $4.6 million adolescents experience negative consequences of alcohol use, such as poor performance in school, discord with parents, or trouble with the law. According to recent studies, alcohol remains as the most widely-used drug among our youth.

Dr. Kleber, I am sure that you are well-acquainted with the tragic effects of illegal alcohol abuse, as well as drug abuse, and I will be particularly interested in your views about addressing the substance abuse crisis in America.

Mr. Chairman, although my schedule will not permit me to remain for the entire hearing, I will review this testimony of Dr. Kleber with great interest.

It is a pleasure to have this distinguished gentleman here, and we are fortunate to have him to be willing to enter Government service.

Thank you, Mr. Chairman.

The Chairman. Thank you.

Senator Simon?

Senator SIMON. Thank you, Mr. Chairman.

Dr. Kleber, we welcome you. You are going to be filling a very, very important spot. One of the temptations for those of us in the United States Senate is to try to find dramatic answers that get a lot of publicity rather than looking for the hard, tough answers. Your new boss is not immune from that same temptation, I should add.

What we have to do is to look for the real answers. Three weeks ago today, I spent the day in Chicago, meeting with addicts, meeting with the U.S. Attorney and his drug task force, spending an hour with a couple of Chicago policemen, making the rounds, working on the drug problem. I talked within the last three days to a sheriff in Illinois. Over and over and over again, I get the answer: We ought to be doing a lot more on education. It is not dramatic, but it is what needs to be done. And on the treatment side, we were meeting a few days ago with some people from New Jersey, where they said they have a 7-month wait now to get into treatment.

We are talking to the people who are receiving treatment in Illinois, and they said most of the treatment is much too short, short-term, quick fix, not helping people enough. All of this is not any news to you, but you are all of a sudden going to be in a position where you can help influence policy, and I hope you try and steer us and the new drug czar of this Nation into a course that looks for real answers, not dramatic answers, not answers that just generate a lot of publicity.

Thank you, Mr. Chairman.

The Chairman. I think, Dr. Kleber, you've got a pretty good idea of the kind of interest and support. I am glad that the Senator from South Carolina mentioned the whole issue of alcohol, because during our visit, we discussed gateway drugs, which include not only alcohol, but marijuana and tobacco, in terms of early use in children. The program that I hope we are going to address is a stopgap program for addicts who are not able to get the treatment and whether there could be some follow-up with those individuals until you can get them into treatment. It is another program that I know you have some familiarity with.

Before I ask you to introduce the members of your family and friends who are here, we are very grateful for the presence of Senator Lieberman, who wants to address the committee and I know has been a strong supporter of yours. We have had the opportunity to talk with him about you and about your qualifications, and he and Senator Dodd have both indicated from their own experience and knowledge and from following this closely, how important your service can be for the country.

So we are very glad to have Senator Lieberman here for whatever comments he would like to make.

STATEMENT OF HON. JOSEPH I. LIEBERMAN, A U.S. SENATOR, FROM THE STATE OF CONNECTICUT

Senator LIEBERMAN. Thank you, Mr. Chairman, and Senator Hatch, Senator Thurmond, Senator Simon.

I am very pleased to be here this morning, not only on my behalf but on behalf of Senator Chris Dodd, who could not be here, to introduce Dr. Herb Kleber as the President's nominee for Deputy Director for Demand Reduction in the Office of National Drug Control Policy.

Mr. Chairman, we in Connecticut are proud that we are offering to the Nation Herb Kleber for what I believe to be one of the most important jobs in the Federal Government today.

I have a statement which I would ask be included in the record of that and in lieu of that just to say a few words.

The Chairman. It will be so included.

Senator LIEBERMAN. Thank you.

Mr. Chairman, I have arrived here new this year, as you know, and so perhaps I have some perspective as one who observed what the 100th Congress achieved in adopting the Omnibus Drug Control Act. I think you recognize there the central truth of this whole effort, which is that there is no single magic bullet in the war on drugs; if we are going to win this war, it is going to have to be fought on all fronts.

You recognized that in the structure of the office that you set up, Demand Reduction and Supply Reduction, two deputies. You recognized it in the requirement that there be equal funding for both demand reduction and supply reduction, and that is the truth. I favor the strongest law enforcement or interdiction efforts, but I also favor the strongest efforts at education and treatment.

We have in Herb Kleber a uniquely-qualified individual to lead the national effort for demand reduction. You have mentioned in your own remarks his credentials, and I need not repeat them. But let me just say that from now more than two decades of knowing Herb Kleber in Connecticut, in New Haven, where we both live and work, that you have somebody here who has technical expertise in some of the frontier treatment methodologies for drug abuse. You have somebody here who has literally been on the front lines. This is not an academician only; this is somebody who has been hands-on in the streets of New Haven with people who are severely drug-addicted.

This is somebody who has gotten into the life of our community, been cochairman of several public task forces on drug abuse and drug treatment.

Perhaps the best way I can tell you how I feel about him or his impact is that a while ago, I brought together some people in Connecticut to talk about drug abuse and law enforcement/treatment people. There was an individual there who now runs one of the largest methadone treatment programs in Connecticut, a very impressive person. I later found out that this was a person who some years ago was a heroin addict who came into one of Herb Kleber's programs and for whom Herb became a mentor. He not only helped her break her addiction; he encouraged her and stuck with her through college, through her master's degree, and now to this extraordinarily result of seeing her not only be involved in drug treatment, but to be the very effective head of one of the largest methadone treatment programs in Connecticut.

I think it is that kind of hands-on combination of technical expertise and caring, that kind of understanding that what we are

dealing with when we talk about drug abuse is at the roots among many people a simple inability at self-discipline, at self-control, at having the values to be able to turn away from the seduction of drugs.

I know Herb well enough to know that he views this as an extraordinary personal opportunity to make a contribution to his country, to have an effect on people in this country, on the problem that is probably more serious than any other one we face. That is a nice spirit with which to come to public service. He understands that it is his opportunity. May I say that I believe, and I gather the members of the committee also believe, that it is America's opportunity to have Herb Kleber assume this position.

So I am very proud that the President made this choice and very personally proud to be here to introduce him to you, to recommend him to you enthusiastically, and without qualification.

Thank you, Mr. Chairman.

The Chairman. Thank you very much, Senator Lieberman. We are very grateful to you for taking the time to come over this morning and make that presentation. You obviously have a good deal of experience and knowledge about the nominee, and we thank you.

Your full statement will be included in the record as well as Senator Dodd's statement.

[Prepared statements of Senators Lieberman and Dodd follow:]

PREPARED STATEMENT OF SENATOR JOSEPH LIEBERMAN

Mr. Chairman, I am pleased to introduce Dr. Herbert Kleber, the President's nominee for Deputy Director for Demand Reduction in the Office of National Drug Control Policy. I am proud that my state of Connecticut can offer the country so highly qualified a nominee for one of the most important positions in the federal government.

Interdiction and law enforcement efforts are important, but they will not suffice if we are to make any progress in the war on drugs in this country. We must come up with ways to reduce our consumption of drugs. We need an educational campaign that engages teachers, the media, and corporate America. We need to engage the greatest scientific and medical minds in the country to devise effective treatment and prevention strategies, including treatment for cocaine and crack addiction. Most of all, we need someone who can orchestrate these efforts and lead the charge.

I am confident that Dr. Kleber is that person. He is one of the leading experts in the United States today on treatment of drug abuse and drug addiction. Dr. Kleber was a Professor of Psychiatry at Yale University School of Medicine, as well as the Director of the Substance Abuse Treatment Unit at the

Connecticut Mental Health Center in New Haven. He is also the Chief Executive Officer of the APT Foundation, the principal drug treatment organization in the New Haven area. He was the Director of the Clinical Research Center for Treatment of Opioid and Cocaine Abuse in New Haven and the Research Fellowship Program in Substance Abuse, both programs that are funded by NIDA.

Dr. Kleber has extensive expertise in research on drug abuse and treatment. He has authored or co-authored over 160 papers on drug abuse. He is on the editorial board of numerous scientific journals, and has received a number of prestigious awards, including the Gold Achievement Award of the American Psychiatric Association, the Foundations Fund Meritorious Service Award, and the ADAMHA Administrator's Award for Public Service.

He has also been actively involved in framing public policy on drug issues, having served as Co-Chairman of the Mayor's Drug Abuse Task Force for New Haven, Connecticut, as a Member of the Governor's Drug Advisory Committee for Connecticut, on the Board of Scientific Counselors of the Addiction Research Center, and on the National Advisory Councils to both the National Institute on Drug Abuse and the National Institute on Mental Health.

Not long ago I had the opportunity to meet someone whose life was profoundly affected by Dr. Kleber. Many years ago, this

person was a heroin addict, who sought treatment in one of Dr. Kleber's clinics. Successful in overcoming addiction, this person went on to make a real contribution in helping others who were similarly afflicted. With Dr. Kleber as a mentor, this person received a college degree and a masters degree, became deeply involved in drug treatment, and now runs one of the largest methadone treatment programs in Connecticut.

It is my hope that, as Deputy Drug Czar, Dr. Kleber can have the same kind of impact on a vastly larger scale -- not just providing guidance and creative ideas on drug treatment and education, but also inspiring others to take up arms in the war on drug abuse.

Herbert Kleber is a scholar, an educator, and a leader. I am confident that he will excel when he takes up his new responsibilities, and I recommend him to this Committee enthusiastically and without qualification.

PREPARED STATETMENT OF SENATOR DODD

Mr. Chairman, members of the committee, I take great pleasure in introducing Dr. Herbert Kleber of Connecticut - the President's nominee for Deputy Director for Demand Reduction at the Office of National Drug Control Policy.

There is no greater, more urgent, or more profound an issue facing us than that of drug abuse. It is devasting a generation of young Americans, resulting in incalculable hurt and waste. More importantly, drug abuse depletes and detracts from our strength and will as a people - just when we need to address and resolve critical problems concerning our economy, environment, and ability to compete with other countries. Progess in these other important areas will not proceed as long as drug abuse is widespread in America.

The key to controlling drug abuse is reducing demand. Decreasing demand is less flashy, but without doubt more fundamental. For so long as drugs are wanted , new supplies (from new suppliers, via new routes, or in the form of new products) will emerge and unfortunately prevail.

Anyone who has fought drug abuse - from the cop on the beat to the Drug Czar - will acknowledge that we are behind the curve, not ahead in this game, losing this war. Because of the voracious appetite for drugs (and the enormous profits generated), efforts to limit supply have easily been overcome. In many areas of South America, producers have more money, arms, resources and wherewithal than the regional authorities.

In retrospect, some of our attempts to reduce supply have been ridiculous. Like the cash inducements to Turkish farmers to stop growing poppies. What remains preposterous is how we have ignored demand reduction as a strategy and have allocated only a quarter of the available funds towards curtailing demand.

(To Dr. Kleber . . .)

Dr. Kleber, I view your office as undoubtably the critical one. If we are to win this struggle, it will largely be by abuse prevention and rehabilitation. We are therefore fortunate that we have a person of your experience, stature, and talent to lead this effort.

(To the Committee . . .)

Dr. Kleber is an internationally renowned authority on drug abuse and its treatment. Professor of Psychiatry at Yale, he is also Director of the Substance Abuse Treatment Unit at the Connecticut Mental Health Center in New Haven and CEO of the APT Foundation - the major treatment site for drug abusers in the New Haven area.

As a researcher, Dr. Kleber has conducted pioneering work in the treatment of narcotic and cocaine abuse. He has authored or co-authored over 160 papers dealing with psychologic, biologic, and treatment aspects of drug abuse. The excellence of his contributions are underscored by his many professional awards - including the Gold Achievement Award of the American Psychiatric Association - and his standing on the editorial boards of eight scientic journals.

In addition, Dr. Kleber has contributed to public policy on substance abuse on the local and national levels. He co-chairs the Mayor of New Haven's Drug Abuse Task Force and serves on the Governor's Drug Advisory Committee in Connecticut. He is a member of the National Advisory Councils to both the National Institute on Drug Abuse and the National Institute on Mental Health.

As a physician, Dr. Kleber is innovative and thoughtful - having helped hundreds of patients in the process. My staff spoke with Dr. Kleber's colleagues in Connecticut who describe him not only as nationally recognized expert, but also as a dedicated, eclectic, and compassionate doctor who goes to great lengths and tries any reasonable approach on behalf of his patients.

And I can add personally how much I have valued Dr. Kleber as a resource for the Subcommittee on Children, Family, Drugs and Alcoholism. He has given generously of his time and wisdom to several of our hearings and helped us better understand the complexities and consequences of substance abuse and its treatments. His nomination in fact came on the eve of one such hearing in Connecticut.

I view Dr. Kleber's appointment with expectation, hope, and enthusiasm. There is no person better qualified for this highly important office; he brings insight, experience, and innovation. His confirmation will be to his individual credit and to our national benefit. And I especially look forward to a continued and enhanced working relationship between our Committee and the new Deputy Director.

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The Chairman. I recognize Senator Pell.

Senator PELL. Thank you very much, Mr. Chairman.

I know that you and my colleague here, Senator Simon, have already eloquently described Mr. Kleber's accomplishments.

It comes as no surprise, then, that President Bush has asked Dr. Kleber to bring his talents to bear on a most important role—telling the people of this Nation that drugs kill.

I think we all recognize that the real solution in the end will be education and to reduce the demand. The ability to interdict the flow of drugs 100 percent, 90 percent, 80 percent, even 50 percent, is impossible but eventually, if we do our jobs, education will do the job. And the message that drugs kill must be communicated to many different people in many different ways.

The young child must be prevented from first experimenting with drugs. We must teach the older child that it is not too late to quit drugs and return to school. We must help the addict realize that the road back to sobriety and health is shorter than any road of drugs.

With every person in our Nation who understands deep within himself or herself that drugs destroy, the drug-free will remain drug-free, and the addict will ask for help. I look forward to that day, and I am very proud of this appointment.

The Chairman. Thank you very much, Senator Pell.

The Chairman. Dr. Kleber, do you have some guests or family members you would like to introduce?

Dr. KLEBER. Yes. Let me introduce briefly Mrs. Rosalind Liss, who has been my administrator and helped start the treatment program with me over 20 years ago. She has provided much of the energy and thought that has gone into making a very successful program.

Second, I would like to introduce my colleague and associate, Dr. Marian Fischman, one of the leading cocaine researchers in the country and an Associate Professor of Psychiatry at Johns Hopkins. She is carrying out very important cocaine research to help us find new treatments. Third, my nephew, Mr. Howard Alter, who works in the Washington vicinity in the area of intelligence analysis.

The rest of my family, unfortunately, is scattered rather widely.

The Chairman. I am familiar with that. Very good. We are delighted to have all of you here, and we welcome you to the hearing.

You may proceed in whatever way you like, Dr. Kleber.

STATEMENT OF DR. HERBERT D. KLEBER, OF CONNECTICUT, NOMINATED TO BE DEPUTY DIRECTOR FOR DEMAND REDUCTION, OFFICE OF NATIONAL DRUG CONTROL POLICY

Dr. KLEBER. I have a few remarks that I would like to make, and then I will be delighted to answer any questions that any of you may have.

I should like to begin by thanking President Bush for nominating me to this post, and I would also like to express my gratitude to Senator Lieberman for his kind words of introduction. I look forward to addressing any committee concerns during the hearing,

and I thank each of the members for their consideration of my views and my nomination.

I have been working in the field of drug abuse for over 20 years. It is clear to me that drug abuse is not a single phenomenon with a single cause. It can have biologic, psychologic, and socio-economic aspects. In any one individual, any one of these factors may be dominant, while in others, all three may share equal weight.

As regards treatment, therefore, drug abusers enter with a wide variety of problems and a range of pre-existing conditions. Some patients have serious psychiatric problems; others have none. Some patients have major social skills and accomplishments and are able to function well in society once you can help them stop their drug abuse. Others do not need rehabilitation, but habilitation, having started drugs at an early age and lacking the basic skills to compete in a complex industrialized society. Some come with criminal records; others do not. Some use primarily one drug; increasingly the patients we see use two or more.

So we know that drug abusers are a heterogeneous group. Therefore, they need different kinds of interventions. In fact, the same addict at a different point in time may need a different intervention. If you see an 18 year-old who has been using drugs for a few years, he needs one approach. If you see that same young man or woman 5 or 6 years later, when they have continued using drugs and have developed a wide host of social and medical problems, they may well need very different interventions.

Please remember also that drug addiction can be a chronic disease, with periods of stability followed by relapse.

As Senator Kennedy and others have indicated, I have done most of my professional work in the area of drug abuse treatment. I believe in this work. It is the humane thing to do, and it has a broader social purpose, since addicts often resort to crime that destabilizes and demoralizes our communities.

I am often asked, "Does treatment work?" I know that question is on your minds as it is on the minds of many Americans. The answer is not a simple one. Yes, treatment does work, but given what I have just described about the complexity of the problem, it also should be clear that no one treatment is appropriate for all drug-abusing individuals. We should be very wary of those who claim to have discovered a "best" or "sole" treatment for addiction. Unfortunately, no such treatment exists today.

Nevertheless, there are thousands of formerly drug-dependent Americans, men and women, now functioning well who have been helped by various treatment approaches or by self-help groups such as AA and NA.

No existing treatment is as effective as we would like. More research, new approaches, and better matching of patients to methods so that scarce resources are used wisely are all needed. If confirmed, I intend to do all I can to effect much-needed improvement in our national drug treatment system.

Prevention is no less important. Again the question is asked: "Can we prevent drug abuse"? and the answer is the same: Yes, we can prevent drug abuse, but not as effectively as we would like.

Certain promising educational approaches may delay or prevent adolescents from starting drug use in school, and two of them have

already been alluded to—the very promising ones in Kansas City and in Seattle. But again, we need better evaluation of what works for whom, and we need to develop new methods of prevention as well. For example, adolescents are one group at high risk for drug use, but they are a heterogeneous group, and they, as individuals, may need very different prevention approaches.

One prevention technique that has still not, in my view, received adequate attention is organized community action. My colleague, Dr. David Musto at Yale, who has studied the history of drug epidemics in America, has noted that what usually seems to turn the tide is a concerted effort by all institutions of society—churches, service clubs, parent groups, employees, law enforcement and health professionals. Drug use does not recede until communities are mobilized against it.

I believe we have begun this process in recent years, but we need to fully push ahead in the future. There are many noteworthy examples of community effort all across the country in individual neighborhoods and in cities. In New Haven, for example, the APT Foundation that I helped to begin in 1970 and have headed, recently started a prevention program with the motto, "Everybody Must Do Something." It is this kind of overall prevention approach that is desperately needed.

The Robert Wood Johnson Foundation's new grant program entitled "Fighting Back"; is providing the impetus for a number of medium-sized cities in America to organize themselves with the "carrot" of extensive funding from the Foundation. I would like the Federal Government to take a greater and more active role as well.

I am interested in this position because I think it is a do-able one. I have been "in the trenches", so to speak, for many years, as Senator Lieberman indicated. I should like to see the trenches get increased national and local assistance. If confirmed, I hope to help coordinate and improve existing treatment and prevention resources. I hope to fight for additional resources where appropriate, and I would like, in addition, to bring a message of hope to the American people. There is much that can be accomplished. This is a battle, but we can turn the tide.

Dr. Bennett and I have spent a considerable amount of time discussing demand reduction issues, and he has assured me that drug abuse treatment, prevention and education will retain a prominent place on the agenda of the Office of National Drug Control Policy. We are both committed to improving the quality and availability of the Nation's drug treatment and prevention programs.

One final word. I am, as has been indicated, a "demand side" person. That has been my work so far and will continue to be my work. But I do not find productive often the largely artificial distinction between "demand" and "supply". The truth is that neither can work without the other. Without adequate coordination of the two, both at the local and national levels, our task becomes much more difficult. Our question is not demand or supply; our duty is to pursue both demand and supply strategies.

The Federal Government must engage all fronts in the war on drugs and must do so in full partnership with our States and local-

ities. Drug use knows no boundaries. The battle against it cannot be won in any one place or with any one method.

Let me close by nothing that on a difficult day when I am working with patients or trying to develop new treatment approaches in our research center, one of the things that sustains me and has for many years is a quote from the Talmud. In rough paraphrase, it goes like this: "The day is short. The task is difficult. It is impossible to complete. We are forbidden not to try."

I appreciate the opportunity to keep trying in this new job, and I again thank this committee for its willingness to consider my nomination.

Thank you.

[Prepared statement and biographical sketch of Dr. Kleber follows:]

Statement of Deputy Director (Demand) - Designate
Herbert D. Kleber, M.D.
Senate Labor and Human Resources Committee
Confirmation Hearing
Monday, July 31, 1989
Washington, D.C.

I would like to begin by thanking President Bush for nominating me to this post. I would also like to thank Senator Dodd and Senator Lieberman for their kind words of introduction. I look forward to addressing any Committee concerns during this hearing and I thank each of the Members for their consideration of my views and my nomination.

I have been working in the field of drug abuse for over twenty years and drug abuse is not a single phenomenon with a single cause. It can have biologic, psychologic, and socioeconomic aspects. While in a single individual, any one of these factors may be dominant, in others, all three may share equal weight. As regards treatment, therefore, drug abusers come with a wide variety of problems and a range of preexisting conditions. Some patients come with serious psychiatric problems, others with practically none. Some have major social skills and accomplishments and are able to function well in society once their drug use has stopped; others need not rehabilitation but habilitation, having started with drugs at an early age and lacking the basic skills necessary to compete in a complex industrialized society. Some come with criminal records; others do not. Some use primarily one drug; the majority abuse two or more.

So drug abusers are a heterogenous group. They need different kinds of "interventions". In fact, the same addict at a different point in time may need a different intervention. An eighteen year old who has been using drugs for a few years may need one approach. If you see him six or seven years later, and he has continued abusing drugs and has developed a wide host of social and medical problems, he may need another. Please remember also that drug addiction can be a chronic disease, with periods of stability followed by relapse.

I have done most of my professional work in the area of drug abuse treatment. I believe in this work. It is the humane thing to do. And it has a broader, social purpose, since addicts often resort to crime that destabilizes and demoralizes our communities.

I am often asked, "Does treatment work?" I know that question is on your minds. The answer is not a simple one. Yes, treatment does work. But, given what I have just described about the complexity of the problem, it should also be clear that no one treatment is appropriate for all drug abusing individuals, and we should be wary of those who claim to have discovered a "best" or "sole" treatment for addiction. Unfortunately, no such treatment exists today.

Nevertheless, there are thousands of formerly drug dependent individuals functioning well in America today -- men and women who have been helped by various treatment methods or by self-help groups such as AA and NA. No existing treatment is as effective as we would like. We need more research, new approaches, better

matching of patients to methods so that scarce resources are used wisely. If confirmed, I intend to do all I can to effect much needed improvement in our national drug treatment system.

Prevention is no less important. Again the question is asked: "Can we prevent drug abuse?" And the answer is the same. Yes, we can prevent drug abuse, but not as effectively as we would like. Certain promising educational approaches may delay or prevent adolescents from starting drug use in school. But again, we need better evaluation of what works for whom, and we need to develop new methods of prevention, as well. Adolescents are one age group at highest risk for drug use. They are a heterogeneous group. And they, too - as individuals - may need very different prevention approaches.

One prevention technique that has still not, in my view, received adequate attention, is organized community action. My colleague David Musto at Yale, who has studied the history of drug epidemics in America, has discovered that what usually seems to turn the tide is a concerted effort by all institutions of society: churches, service clubs, parent groups, employees, law enforcement and health professionals. Drug use does not recede until entire communities are mobilized against it.

I believe we have begun this process well in recent years. And I believe we need to fully push ahead in the future. There are many noteworthy examples of needed community effort all across the country in individual neighborhoods and in cities. The Robert Wood Johnson Foundation's new grant program is

providing the impetus for some of them. I would like the federal government to take a greater and more active role as well.

I am interested in this position because I think it is a doable one. I have been "in the trenches", so to speak, for many years. I would like to see the trenches get increased national and local assistance. If confirmed, I hope to help coordinate and improve existing treatment and prevention resources. I hope to fight for additional resources where appropriate. And I would like to bring a message of hope to the American people. There is much that can be accomplished. This is a battle, but we can turn the tide.

Dr. Bennett and I have spent a considerable amount of time discussing drug treatment issues and he has assured me that drug abuse treatment, prevention and education will retain a prominent place on the agenda of the Office of National Drug Control Policy. We are both committed to improving the nation's drug treatment programs.

One final word -- a plea for proper understanding. I am, as they say, a "demand-side" person. That has been my work so far, and it will continue to be my work. But I am frustrated by largely artificial distinctions between "demand" and "supply". The truth is that neither can work without the other. Without adequate coordination of the two, both at the local and national levels, our task becomes much more difficult. Our question is not demand or supply? Our duty is to pursue both demand and supply strategies. The federal government must engage all fronts in the war on drugs, and must do so in full partnership with our

states and localities. Drug use knows no boundaries. The battle against it cannot be won in any one place or with any one method.

On a difficult day in my clinical and research work with addicts, one of the things that sustains me is a quote from the Talmud. In rough paraphrase, it goes like this:

"The day is short.
The task is difficult.
It is impossible to complete.
We are forbidden not to try."

I would like to keep trying in this new job. And I again thank this Committee for its willingness to consider my nomination.

STATEMENT FOR COMPLETION BY PRESIDENTIAL NOMINEES

PART I: ALL THE INFORMATION IN THIS PART WILL BE MADE PUBLIC

Name: Kleber (LAST) Herbert (FIRST) David (OTHER)

Position to which nominated: Deputy Director (Demand) - ONDCP Date of nomination: 7-14-89

Date of birth: 19 (DAY) 06 (MONTH) 34 (YEAR) Place of birth: Pittsburgh, Pennsylvania

Marital status: Divorced Full name of spouse:

Name and ages of children: Elizabeth F. Kleber-Wynne Age 32

Marc S. Kleber Age 29

Pamela R. Kleber-Shad Age 26

Education:

Institution	Dates attended	Degrees received	Dates of degrees
Dartmouth College	9/52-6/56	A.B.	1956
Jefferson Medical College	9/56-6/60	M.D.	1960
University of Pittsburgh Health Center Hospitals	7/60-6/61	Internship	
Yale University School of Medicine	7/61-6/64	Psychiatric Residency	

Honors and awards: List below all scholarships, fellowships, honorary degrees, military medals, honorary society memberships, and any other special recognitions for outstanding service or achievement.

Editorial Board of six scientific journals.

Lederle Research Fellowship - 1959; M.A. (Hon.) Yale - 1975; Fellow, American Psychiatric Association; Fellow, American College of Neuropsychopharmacology; American Psychiatric Association's Gold Award - 1975; Governor's Drug Advisory Council, State of Connecticut 1970-1976; Initial National Advisory Council to NIDA 1975-1979; National Advisory Council to NIMH 1977-1979; Lapides Foundation Fund Meritorious Service Award 1979; American Psychiatric Association, Foundation's Fund Prize for Research in Psychiatry 1981 (Co-Winner); Board of Scientific Counselors of the Addiction Research Center (ARC) of the National Institute on Drug Abuse June 1982-1985; Executive Committee, Committee on Problems of Drug Dependence, Inc. (CPDD) 1985-1989; Nolan D.C. Lewis Visiting Professor, Carrier Foundation 1985; Balassone Memorial Lecture, University of Maryland 1986; Visiting Professor, University of London, Institute of Psychiatry 1986; 2nd Thomas James Okey Memorial Lecture, University of London, Institute of Psychiatry 1987; Nyswander and Dole Award 1986; ADAMHA Administrator's Award for Public Service 1986; American Academy of Psychiatrists in Alcoholism and Addictions Founders Award 1987; Governor's Award for Outstanding Service in the field of Substance Abuse, Hartford,Ct.1987; Institute of Medicine Substance Abuse Coverage Committee 1988-89.

Memberships: List below all memberships and offices held in professional, fraternal, business, scholarly, civic, charitable and other organizations for the last five years and any other prior memberships or offices you consider relevant.

Organization	Office held (if any)	Dates
Fellow, American Psychiatric Association		
Fellow, American College of Neuropsychopharmacology		
Executive Committee, Committee on Problems of Drug Dependence, Inc.		
Consultant, APA Committee on Drug Abuse		
Member, APA Task Force on Benzodiazepine Dependency		
Co-Chairman, Mayor's Task Force on Drugs, New Haven, Ct.		
Member, American Academy of Psychiatrists in Alcoholism and Addictions (AAPAA)		
Member, Institute of Medicine Substance Abuse Coverage Committee		
Member, American Medical Association		

Employment record: List below all positions held since college, including the title or description of job, name of employer, location of work, and dates of inclusive employment.

Professor of Psychiatry, Yale University School of Medicine, New Haven, Ct. 7/66-Present.

Chief Executive Officer, APT Foundation, New Haven, Ct. 7/86-Present.

Psychiatric Consultant, Choate Rosemary Hall, Wallingford, Ct. 9/77-6/85.

Psychiatric Consultant, Hamden Hall Country Day School, Hamden, Ct. 9/71-6/77.

Psychiatric Consultant, Wesleyan University, Middletown, Ct. 9/66-6/88.

Surgeon, USPHS and Director of Admission Unit, U.S.P.H.S. Hospital, Lexington, Ky. 7/64-6/66.

Research Fellow, Jefferson Medical School-Department of Pharmacology, Philadelphia, Pa. 6/57-8/57.

Government experience: List any advisory, consultative, honorary or other part-time service or positions with Federal, State, or local governments other than those listed above.

Food & Drug Administration (FDA) Drug Abuse Advisory Committee 1987-1990.

Ad Hoc ADAMHA Committees relating to formulation of drug abuse policy 1980-1988.

Published writings: List the titles, publishers and dates of books, articles, reports or other published materials you have written.

See enclosed list of 168 publications.

Political affiliations and activities: List all memberships and offices held in or financial contributions and services rendered to all political parties or election committees during the last five years.

None.

Future employment relationships:

1. Indicate whether you will sever all connections with your present employer, business firm, association or organization if you are confirmed by the Senate.

Yes.

2. State whether you have any plans after completing government service to resume employment, affiliation or practice with your previous employer, business firm, association or organization.

See #3.

3. Has a commitment been made to you for employment after you leave Federal service?

Yale University permits up to 2 years of unpaid leave of absence for tenured faculty who enter government service. No benefits continue during this period. No severence pay or promises of future payment arount exist. Whether I will use this is not currently clear.

4. Do you intend to serve the full term for which you have been appointed or until the next Presidential election, whichever is applicable?

I hope to

Potential conflicts of interest:

1. Describe any financial arrangements, deferred compensation agreements or other continuing financial, business or professional dealings with business associates, clients or customers who will be affected by policies which you will influence in the position to which you have been nominated.

None.

2. List any investments, obligations, liabilities, or other financial relationships which constitute potential conflicts of interest with the position to which you have been nominated.

None.

3. Describe any business relationship, dealing or financial transaction which you have had during the last five years whether for yourself, on behalf of a client, or acting as an agent, that constitutes a potential conflict of interest with the position to which you have been nominated.

1. Yale University School of Medicine, Professor of Psychiatry (on faculty from 1966-Present). 2. APT Foundation - Chief Executive Officer and Member of Board of Directors 1986-Present (Consultant 1970-1986). 3. I have given numerous lectures at medical schools, professional meetings, and continuing medical education courses. In some of these, my honorarium and travel was paid by the medical school or professional group; at other times it was paid directly to me by a pharmaceutical company which sponsored the lecture; and at other times the companies made an educational grant to the school or group which then paid my fee and travel. Such sponsorship was publicly acknowledged at the time of the lecture. Companies included Merrell-Dow, DuPont Pharmaceuticals, Upjohn, Lilly, and Pfizer. In addition, I have consulted to Boehringer-Ingelheim Co. and testified before the Expert Committee on Drug Dependence of the World Health Organization in Geneva, Switzerland at their request; and before the Committee on Safety of Medicines in London, England at the request of DuPont. 4. National Medical Consultant for Substance Abuse to CIGNA, 1986-1987.

4. List any lobbying activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat or modification of any Federal legislation or of affecting the administration and execution of Federal law or policy.

None.

5. Explain how you will resolve any potential conflict of interest that may be disclosed by your responses to the above items.

I will disqualify myself from any matter that presents, or to a reasonable person could appear to present, a conflict of interest. It is unlikely, given the nature of the Office and my duties, that such situations would present themselves.

H.D. Kleber, M.D. VITA

PUBLICATIONS

1. Kleber, H.D. and Manthei, R.W.: Influence of Nicotinic Acid and Nicotinamide on Insulin Hypoglycemia. Proceedings of the Society for Experimental Biology and Medicine 107, 1961.

2. Kleber, H.D.: Student Use of Hallucinogens. Journal of the American College Health Association 14(2):109-117, December 1965.

3. Kleber, H.D.: Prolonged Adverse Reactions from Unsupervised Use of Hallucinogenic Drugs. The Journal of Nervous and Mental Disease 144(4):308-319, 1967.

4. Imperi, L.L., Kleber, H.D. and Davie, J.S.: Use of Hallucinogenic Drugs on Campus. The Journal of the American Medical Association 204:1021-1024, June 17, 1968.

5. Kleber, H.D.: Narcotic Addiction - The Current Problem and Treatment Approaches. Connecticut Medicine 33(2):113-116, Feb. 1969.

6. Kleber, H.D. The New Haven Methadone Maintenance Program. The International Journal of the Addictions 5(3):449-463, Sept. 1970.

7. Bowers, M. and Kleber, H.D.: Methadone Increases Mouse Brain 5-Hydroxyindoleacetic Acid (SHIAA). Nature 229:134-135, Jan. 1971.

8. Kleber, H.D. and Gould L.C.: Urine Testing Schedules in Methadone Maintenance. The Journal of the American Medical Association 215(13):2115-2116, March, 1971. (Letter).

9. Bowers, M., Kleber, H.D. and Davis L.: Acid Monoamine Metabolites in Cerebrospinal Fluid During Methadone Maintenance. Nature 232: 581-582, Aug. 1971.

10. Kleber, H.D. and Klerman, G.L.: Current Issues in Methadone Treatment of Heroin Dependence. Medical Care 9(5):379-382, Sept.-Oct., 1971.

11. Pierson, P.S., Howard, P. and Kleber, H.D.: Sudden Deaths in Infants Born to Methadone Maintained Addicts. The Journal of the American Medical Association 220:1733-1734, June, 1972.

12. Kleber, H.D.: Clinical Experiences with Narcotic Antagonists in Opiate Addiction: Origins and Treatment, S. Fisher and A.M. Freedman (eds.). V.H. Winston & Sons, Inc., pp. 211-220, 1973.

13. Cohn, G.L., Cramer, J.A. and Kleber, H.D.: Heroin Metabolism in the Rat. Proceedings of the Society for Experimental Biology and Medicine 144(1):351-355, Oct. 1973.

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15. Pierson, P.S., Rapkin, R.M. and Kleber, H.D.: Naloxone in the Treatment of the Heroin Addicted Adolescent. American Journal of Alcohol and Drug Abuse 1(2):243-252, 1974.

16. Kleber, H.D.: The Treatment of Acute Heroin Toxicity. In A Treatment Manual for Acute Drug Abuse Emergencies. National Clearinghouse for Drug Abuse Information, pp. 17-21, 1974.

17. Kleber, H.D.: Drug Abuse in A Concise Handbook of Community Psychiatry and Community Mental Health, L. Bellak (ed.), Grune & Stratton, Inc., pp 129-162, 1974.

18. Kinsella, J.K., Aficano, A., Rapkin, R. and Kleber, H.D.: A Comprehensive Approach to the Treatment of Drug Dependence. American Journal of Drug and Alcohol Abuse 1(3):313-327, 1974.

19. Gould, L. and Kleber, H.D.: Changing Patterns of Multiple Drug Use Among Applicants to a Multimodality Drug Treatment Program. Archives of General Psychiatry 31:408-413, Sept. 1974.

20. Kleber, H.D.: The Drug Dependence Unit of the Connecticut Mental Health Center in Organization and Administration of Drug Abuse Treatment Programs, J.G. Cull and R.E. Hardy (eds.). Charles C. Thomas, pp. 51-60, 1974.

21. Cohn, G.L., Cramer, J.A. and Kleber, H.D.: Heroin and Morphine Binding with Human Serum Proteins and Red Blood Cells. Proceedings of the Society for Experimental Biology and Medicine 147(3):664-666, 1974.

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23. Dy, A.J., Howard, P. and Kleber, H.D.: The Nurse in the Methadone MAintenance Program: Expansion and Transitions in Role. Journal of Psychiatric Nursing 13:17-20, 1975.

24. Ungerer, J.C., Harford, R.J. and Kleber, H.D.: Uses of Psychological Research Instruments in Drug Abuse Therapy. Proceedings, 2nd National Drug Abuse Conference, New Orleans, April 1975.

25. Riordan, C., Mezritz, M., Slobetz, F. and Kleber, H.D.: A Follow-up Study of Successfully Detoxified Metahdone Maintenance Patients. Journal of the American Medical Association 235:2604-2607, 1976.

26. Harford, R.J. and Kleber, H.D.: Measuring Unprescribed Drug Use with Random Interval Urinalysis Schedules. Proceedings, 3rd National Drug Abuse Conference , New York, March 1976.

27. Miller, D.J., Slobetz, F., Kleber, H.D. and Bloomer, J.R.: Effect of Drug Withdrawal on Hepatic Abnormalities in Parenteral Narcotic Addicts. Gastroenterology 70(5):Pt.2 A-129/987, 1976.

28. Berberian, R.M., Thompson, W.D., Kasl, S.W., Gould, L.C. and Kleber, H.D.: The Relationship Between Drug Education Programs in the Greater New Haven Schools and Changes in Drug Use and Drug Related Beliefs and Perceptions in Health Education Monographs 4(4):327-376, 1976.

29. Hurzeler, M., Gurwitz, D. and Kleber, H.D.: Varying Clinical Contexts for Adminstering Naltrexone in Narcotic Antagonists: Naltrexone, N.I.D.A. Research Monograph, Number 9, September 1976.

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31. Gould, L.C., Berberian, R.M., Kasl, S.V., Thompson, W.D. and Kleber, H.D.: Sequential Patterns of Multiple-Drug Use Among High School Students. Archives of General Psychiatry 34:216-222, 1977.

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33. Kleber, H.D.: Methadone Maintenance Treatment - A Reply. American Journal of Drug and Alcohol Abuse 4(2):267-272, 1977.

34. Kleber, H.D.: Detoxification from Methadone Maintenance: The State of the Art. Int. J. Addict. 12(7):807-820, 1977.

35. Kleber, H.D. Clinical Aspects of the Use of Narcotic Antagonists: The State of the Art. Int. J. Addict. 12(7):857-861, 1977.

36. Weiner, H. and Kleber, H.D.: Basic Administration Principles for Drug Abuse Treatment Programs. National Drug Abuse Center Medical Monograph Series. Dendy, R.F. and Schnoll, S.H. (eds.) 1(3), August 1977.

37. Harford, R.J. and Kleber, H.D.: Comparative Validity of Random Interval and Fixed Interval Urinalysis Schedules. Arch. Gen. Psychiat. 35:356-359, 1978.

38. Gold, M.S., Donabedian, R.K., Dillard, M., Slobetz, F.W., Riordan, C.E. and Kleber, H.D.: Antipsychotic Effect of Opiate Agonists. Lancet 11(8034):398-399, 1977.

39. Gold, M.S., Redmond, D.E. and Kleber, H.D.: Clonidine in Opiate Withdrawal. Lancet 1(8070):929-930, 1978.

40. Report of the National Research Council Committee on Clinical Evaluation of Narcotic Antagonists: Clinical Evaluation of Naltrexone Treatment of Opiate-Dependent Individuals. Arch. Gen. Psychiat. 35:335-340, 1978.

41. Kleber, H.D.: Treatment - Past and Future in Treatment Aspects of Drug Dependence, A. Schecter, and S.J. Mule (eds.). West Palm Beach Florida: CRC Press, pp. 235-239, 1978.

42. Gold, M.S., Redmond,Jr., D.E. and Kleber, H.D.: Clonidine Blocks Acute Opiate-Withdrawal Symptoms. Lancet :599-602, Sept. 16, 1978.

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47. Gold, M.S., Pottash, A.L.C., Sweeney, D.R., Kleber, H.D. and Redmond, Jr., D.E.: Rapid Opiate Detoxificatio: Clinical Evidence of Antidepressant and Antipanic Effects of Opiates. Amer. J. Psychiat. 136(7):982-983, 1979.

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49. Gold, M.S. and Kleber, H.D.: A Rationale for Opiate Withdrawal Symptomatology. Drug Alcohol Dependence 4:419-424, 1979.

50. Miller, D.J., Kleber, H.D., and Bloomer, J.R.: Chronic Hepatitis Associated with Drug Abuse: Significance of Hepatitis B Virus. Yale J. Biol. Med. 52:135-140, 1979.

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53. Gold, M.S., Pottash, A.C., Sweeney, D.R. and Kleber, H.D.: Opiate Withdrawal Using Clonidine. J. Amer. Med. Assoc. 243(4):343-346, 1980.

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The Chairman. Thank you very much, Doctor, for an impressive statement.

We'll follow a 10-minute questioning period, and I'll ask the clerk to notify the Senators when their time is up.

Should you be approved, and I expect you will be by the end of the week, in the area of the demand side, where are your priorities going to be? What would be the initial steps that you would take to deal with your responsibility as the individual in charge of the demand side aspect of the war on drugs?

Dr. KLEBER. Of course, the very initial step will be to work on the strategy that is due out on September 5th. And although it is late, and much of the strategy has already been written, I would hope to have some input into that in the remaining month or so before it finally is presented to the country.

The strategy, of course, will give certain guidelines for what the office would like to see happen, and I am not going to preempt that in my comments today. I would say that there are clearly a number of areas that I would want to start on very quickly.

One, data. One of the things that has amazed me is how little we know about what is going on. It is amazing how much the whole data resource system has been gutted. The data that the Government has or States have as to what kind of treatment is going on, who is in treatment, how are they doing, is woeful. One of the areas we need to set into place, if we are going to measure whether we are going to be effective with our scarce tax dollars, is what are we already getting from the money and what can we do to improve that.

Second, I want very much to see an expansion of our treatment system. Everywhere I go around the country, I hear about waiting lists. In New Haven, we had over 100 people waiting for our cocaine treatment program. We had a 4- to 5-month wait for our heroin treatment program—and that is not unique. I hear that in many, many places, large cities and small cities. So one of the immediate actions necessary is to see about how are we going to increase the treatment system to make it more available for those individuals who need it.

I should mention, by the way, that the scarcity in the treatment system is much more in the public treatment system. There apparently, as far as I can tell, is no scarcity in the private treatment system. If you have funds, if you are insured, in general you can get help. It is for the millions of Americans who have to depend on the public system that there is less available then necessary, and much needs to be done. Both quantity and quality needs to be increased.

Simultaneously, we need to do something on prevention. I want to start meeting with various prevention groups and community groups. I think we need to figure out ways to activate communities, to get them involved. There are some ideas that are going to be coming up in the strategy about ways to get communities better involved, and I think that will simultaneously happen, because it is clear that treatment alone cannot be the answer. We now have, again—and I don't want to be parochial, but I keep referring to New Haven because that's where I have the hands-on experience—we have over 1,000 patients per day in treatment in a city of just

over 140,000 or so. We have added over 200 treatment slots in the last few years, and we could probably add another 500 treatment slots. So treatment alone cannot be sufficient. We are going to have to do more about prevention. Otherwise we will be adding and adding and adding new treatment.

So I would want to work on both simultaneously, to try and get things going at the same time.

The Chairman. Would research as well fit into your priorities in terms of what is working and what is not working? Maybe that is included in your assessment of the data.

Dr. KLEBER. There are two kinds of research. One is to evaluate what is already going on, and that is what I was referring to. The second, which is equally critical is that clearly we don't have the answers for some forms of treatment, cocaine and crack in particular. The treatment methods that we and others have developed are not yet good enough. We need better approaches, and research is absolutely critical to try and figure out better ways of treatment.

I am hopeful that in the next two to four years, our treatment programs, especially for cocaine, will have new methods that will do much more than our current methods do.

The Chairman. Let me just go back into those areas that you mentioned. In the area of prevention, you talked about community groups. Do you also see an important role for the school systems, the education system, in our country, to be involved as we have seen both in Kansas City and in Seattle, where you had education and parental as well as community involvement? Could you talk a little bit about the educational institutions in this area of prevention, and then could you describe how young do you think you can start this process?

Dr. KLEBER. School-based intervention or prevention programs are very important. What you try and do in these school-based programs is really give the youngsters, among other things, resistance training so that when they are approached—and it is usually by their peers—to try drugs, that they have the skills to be able to resist that kind of temptation. It is unlikely, given what we all know about the supply side, that we are going to be able to make drugs unavailable. And since we cannot make them physically unavailable, we have to work with these students to try and make drugs psychologically unavailable by giving them the skills, the resistance training, and also in some cases, giving them the alternative incentives to resist drugs.

So I think school-based programs are important. What I like about the Kansas City model is that it has both effective school-based intervention and at a relatively cheap price. My recollection from Kansas City is that it costs less than $40 per student per year for the school-based part of their program, and importantly they also have a control group. But what is especially useful about the Kansas City model is that it involves not just the school; it involves the parents, it involves the media, and it involves the larger community.

The Chairman. How early in the education system do you think it can be started?

Dr. KLEBER. I think that is a question of with which group you are working. We have heterogeneous populations out there. In

some areas, I don't think you ought to start drug education before fifth or sixth grade. To start talking with kids in kindergarten and first grade about marijuana, about alcohol and about tobacco is going to perhaps do more harm than good. However, there are health education activities one can do in those early years.

In other areas where drug use is being started at incredibly early ages, where by nine they are already using, you may need to start specific kinds of drug education very early, as early, perhaps, as first grade. So I believe you start early, but the content of has to be thought through and made applicable to the group with whom you are working. I don't think we are going to come up with just one prevention method you apply everywhere. Instead we need to come up with better prevention methods that are tailored to the group.

The Chairman. My time is running down, and I will come back in a later round, but in the last drug bill, we had allocated resources, about 50 percent equally in terms of demand side and supply side. Recent funding date shows that about 75 percent is dedicated to the supply side and 25 percent to the demand side. If you are confirmed, how strong an advocate are you going to be in terms of doing the kinds of things that you have outlined here this morning and ensuring that the program that we will have before the Congress will be the kind of balanced program which your testimony has indicated that you support. How much assurance can you give us that you are going to battle for these points, which as you have testified have an important impact on the over-arching problem?

Are we going to be a real advocate in you?

Dr. KLEBER. Absolutely. I haven't gotten where I am without fighting. We had to develop our programs in Connecticut—they were not given to us. In many cases, we had to get enormous citizen support to convince the legislators and administrators at the various centers of government, locally and statewide, that funds were necessary, and we were willing to do battle. I am willing to do battle, and I assure you I will fight both within the office and in Congress and in the Nation as a whole to make sure the demand side gets adequately represented.

It is clear we can do things on the demand side. If you look at the numbers: for example, marijuana has sharply decreased in the last eight to nine years, in spite of the fact that it is more available than ever on our streets. So that kind of demand reduction is where we have to go.

The Chairman. Thank you very much.

Senator Hatch?

Senator HATCH. I have really appreciated some of the comments you have made. I look at some of the Department of Education programs where they have cooperated with the Alcohol, Drug Abuse and Mental Health Administration, and of course they have also cooperated with national and local community organizations. The success has been reported in some of the surveys of high school students.

However, I understand that we as a Nation have not been nearly as successful in reaching those not in school and those who grew up in the Sixties, an era where it seemed that society more or less condoned drug abuse or use.

Will you share with us your thoughts concerning how you reach the dropout and the adult user of drugs and what you hope you can do in this position with regard to those two groups?

Dr. KLEBER. Your points are very well-taken in that not only is drug use very high among these groups, but they are inadequately measured, because they are the hardest group to try and reach. I don't think we even know how much drug use there is among the dropouts, but I would guess it is substantially higher than among those who remain in school.

I believe there are at least a couple of places where you can reach those individuals. One is in the workplace. To the extent that they are employed, workplace programs including employee assistance programs can be useful. Working with families: although they have dropped out of school, often they still are connected with their families. Various activities in the community: there was one endeavor recently from a community that started a midnight basketball league in blocks that had heavy drug use. Some of the people they were able to reach were, I am sure, some of those dropouts that otherwise would be spending that time on less productive activities including drug use. And of course, we know that evenings and weekends are favorite times for using drugs, and they used that midnight basketball as a way to get youngsters involved and then work them into other things, get some of them to return to school, get some involved in job training. It also helped to make the area safer.

So I believe there are innovative ways to try and reach those people. You try and look at where are they, what systems do they have any connection with, and are there ways to reach them at that point.

If they have already heavily gotten into drugs, then they may come to the attention of either the treatment system or the criminal justice system. We need more treatment programs in prison as well. The figures that we have heard are that in many cities, up to 80 percent of the people arrested test positive for drugs at the time of arrest, and in general over 50 percent of individuals in our prisons are there in some way related to drug or alcohol abuse.

I believe, therefore, we need to do more about prison programs because that is where many of the people are and as well come up with alternatives because clearly we cannot build enough cells. We need to come up with alternatives to try and treat people without putting them into prison.

Senator HATCH. There has been a lot of discussion especially recently about the use of methadone treatment. What do you think the Federal role should be there?

Dr. KLEBER. Well, methadone is similar to what Winston Churchill once said about democracy: It is a dreadful form of government until you compare it to the others. That's a rough paraphrase. I believe methadone falls somewhat into that category. It is an addicting narcotic, and ideally we would like an approach that did not substitute one narcotic for another.

Unfortunately, our other treatments are not as effective as we would like, and methadone, for many, many patients for whom it is used, seems to be quite effective. There are major drops in crime, in drug-seeking activities. There is increased employment. People

are available for psychological help. So that methadone right now is one of the mainstays of our treatment system for heroin. It does need to be improved. There was a recent study by John Ball from NIDA's Addiction Research Center, showing a wide discrepancy between programs, with some achieving a 90-percent reduction in I.V. drug use and others only achieving a 45-percent reduction. So the ability and knowledge are out there, but we need to strengthen the programs so we can get more of them at the 90 percent level.

My prediction is we are going to need more heroin slots in the future. We are already seeing in some parts of the country, especially on the two coasts, a number of individuals using cocaine with heroin. If our experience in the past with stimulant epidemics is any indication, we are going to see much more heroin addiction in the early Nineties, so programs like methadone are going to remain critically important.

Senator HATCH. One last question. An AIDS epidemic, of course, is confronting our country, and it is growing greatest among those who participate in illegal drug use. Now, what are your views in reaching the intravenous drug user to decrease the risk of transmission of AIDS?

Dr. KLEBER. The drug abusers have been much slower to change their risky behavior as compared, for example, to the gay community. As a result, increasingly, new cases of AIDS are from I.V. drug abusers—and not just I.V. drug abusers, but cocaine abusers as well. AIDS is increasing among crack abusers, where sex-for-crack is spreading. We then increased sexual transmission of the HIV virus.

One of the best ways to reach those people is with various innovative outreach techniques that NIDA has tried to innovate. They recently gave a number of grants to communities—New Haven was one of them—to try and reach addicts who were not in treatment, to get them to come into treatment, to educate them about the dangers of AIDS.

In the New Haven program, we have a mobile van that goes around to high-risk areas. We have people going door-to-door. We have a storefront. We try and enlist the sexual partners of addicts as well as addicts not in treatment. We offer well-baby checkups to try and encourage women to come in, to then talk to them about what their I.V. drug-abusing partners may be doing and to get them to come in for help.

So there are ways you can go into the community, using staff who are comfortable in shooting galleries and on the streets, to get addicts to come in or to educate them about the dangers of AIDS. You, of course, need to be able to offer them something when they come in. It is hard to encourage people to come in for help and then have nothing to offer them when they come in. So we need simultaneously to get them to come in and have something there for them when they do.

It is very hard to change the behavior of addicts. In a recent study done in New Haven, it was found that something like 75 to 80 percent of the addicts not in treatment knew practically everything we would have wanted them to know about AIDS. They knew how it was transmitted; they knew it could be fatal; they knew you could get it even from someone who appeared healthy; they knew

the methods to use not to get it—but over three-quarters of them continued to engage in the kind of behavior they had just said 5 minutes earlier could kill them.

So knowledge alone does not seem to be sufficient. We need to figure out other ways to do it.

Senator HATCH. Thank you very much.

The Chairman. Senator Pell?

Senator PELL. Thank you, Mr. Chairman.

I have three specific questions. One, it is often said that the greatest cash crop in California is marijuana. Is that a correct statement or not, in your view?

Dr. KLEBER. Well, we hear those statements—the greatest cash crop, the third cash crop. I certainly don't know whether it is exactly true or not. I would say, however, that the gist of it is true, that it is a very important cash crop in a number of our Western States and in Hawaii.

Senator PELL. Thank you.

Second, we know that many crimes are committed through drug addiction by addicts having a craving that they want to satisfy. But is the influence of hard drugs as conducive to crime as is alcohol?

Dr. KLEBER. There are a number of different ways that drugs and alcohol interact with crime. With alcohol, what you have is often an intoxicating or disinhibiting substance that people use right before they commit crimes as a way of artificially bolstering courage, making it easier for them to engage in certain kinds of behavior. And of course, there are other kinds of crime, the nonmonetary crimes, where alcohol is very much involved, the crimes of violence as people get intoxicated and then engage in violent behavior that they otherwise might not have.

With drugs, you have a somewhat different relationship with crime. One, you do have this last connection—certainly, the connection with violence is there. Cocaine—even if cocaine were free, you would have a fair amount of crime connected with people who had taken it because cocaine is par excellence a drug that is conducive to violence. It produces irritability, paranoia, and a need to act, a need for motion, for action. And what that can mean is that the guy who looks at you cross-eyed on the subway, you slam out at him.

What we are seeing with crack and other forms of cocaine is a marked increase in senseless violence; people just lashing out and behaving in a way that is destabilizing to any civilization.

You also have the crime connected with acquisition—that is, the drugs are so desirable that they want as much as they can, and in order to get as much as they can, they often have to engage in crime to do that. Even where drugs are cheap, it may not reduce that kind of crime substantially, because people keep wanting more. So you both have more people using it and the same individual needing to engage in some criminal activity to get the wherewithal.

Then recently what we have seen in Washington and some other cities is distribution crime—that is, the crime connected with turf battles, with various gangs fighting for control. We did not see as much of that in the heroin era. It was much more of a controlled

system. Cocaine has flooded the market so much that we get more into gang warfare than happened in the recent past with heroin.

These are some of the different ways that drugs and alcohol interact with crime.

Senator PELL. Finally, as I understand it, in some countries like Great Britain, some drugs are legalized. A heroin addict, for example, is given the heroin once a week or whatever it is that he has to have it. Do you believe in the end that that approach could be followed constructively, or do you think the present absolute banning is the correct approach?

Dr. KLEBER. The English system has been incredibly misunderstood, and there are some Americans who have, unfortunately, contributed to that misunderstanding. I had the advantage of spending a 6-month sabbatical in London in 1986 and had a chance to really study the system. In general, they do not give heroin. That stopped in about 1975. They estimate that there are between 60,000 and 100,000 heroin addicts in England and less than 100 who are being given heroin through the National Health Service, and those are mainly the old-timers who were still getting it back in 1975. They have not started people on it anew for many, many years.

Instead, what they did in the mid-Seventies was for the most part switch over to methadone. Methadone or outpatient drug free are the mainstay of their treatment system now.

One of the things I also learned when I was in England is that we are two countries divided by a common language. It wasn't until I had been there for a few months that I learned that when we say "methadone maintenance" and when they say "methadone maintenance", we mean two totally different things. Our methadone system here is a distributive one; that is, most individuals have to come to the clinic and take their methadone onsite and maybe a few days a week, when you have earned it and your urines are clean, you can get some take-out. England never went to that system. They have a prescriptive system. You go to the clinic, and get a prescription for 2 weeks' worth of methadone. You take that to the chemist shop, fill it, and, what they are finding, is that many of the addicts then sell their methadone and use it to buy heroin. And then they say, oh, methadone maintenance doesn't work when it is not really being tried.

Some doctors now in England are coming around to the position that they should switch from a prescriptive system to a distributive one where you really monitor the behavior and make sure that the individual is taking the methadone and not just giving them the wherewithal to sell the methadone and buy heroin. While more successful, a distributive system is also more expensive.

Senator PELL. Thank you.

The Chairman. Senator Simon?

Senator SIMON. Dr. Kleber, in response to a question by Senator Kennedy, you said the data resource system has been gutted. Who has been collecting this, and why has it been gutted?

Dr. KLEBER. In the Seventies, the money for treatment was given out through the National Institute on Drug Abuse, and States were required in return to report back to the Federal Government statistics on the system—who they treated, what kind of treatment, et cetera. In the early Eighties, that mandatory reporting by the

States was dropped. Since 1981 or 1982, the States have no longer been required to submit that data to the Federal Government, and as a result, the Federal Government has to rely on the good will of States. I believe 15 States still submit that data, but clearly, that is 15 out of 50.

I think we need to go back to a mandatory system where, in return for receiving funds from the Federal Government for treatment, that the reporting requirements get reinstituted.

Senator SIMON. And you will push for that?

Dr. KLEBER. Absolutely.

Senator SIMON. Good.

Did you by any chance read in yesterday's and today's Washington Post the story of a 6-year-old and what that little 6-year-old is going through?

Dr. KLEBER. No, I didn't have the chance.

Senator SIMON. You really ought to get hold of that, and all of us ought to. If there have been any two articles that deserve a Pulitzer Prize—you see graphically in this life of a 6-year-old—it is just stunning reading.

You mentioned the penal system. The problem is obviously in the penal system first, generally, you cannot read and write when you go into prison. So we need also to give people some options when they come out. But we also need drug education there. And a number of States—because drugs unfortunately are available in prison, not legally—but a number of States require that there be drug testing before parole. The Federal Government does not require that.

Do you have any observations on that?

Dr. KLEBER. Well, there clearly should be drug testing both before parole and after they leave prison. We know that addicts are most at risk for relapse within the first 30 to 90 days after they leave prison. It seems to me that we have an obligation to do this on the basis of data already published, which shows that close supervision—Dr. George Valiant showed that in his studies in the early Sixties—that close monitoring of these individuals when they leave prison is associated with a much higher drug-free outcome.

So we really need to put some teeth into the probation and parole system. That is one of the things I meant near the end of my statement when I talked about the interaction between the demand and the supply side. There needs to be that kind of teeth from the criminal justice system so that individuals who use drugs when they leave prison, are quickly told they have to get into treatment, and if they don't, then they go back to prison. I think we need that kind of enforcement in the system.

Senator SIMON. I agree. Finally, in Illinois—we are each of us somewhat parochial; we judge the universe by our own State—what is happening is that we are having law enforcement for drug traffickers and basically ignoring the problem of users. We don't have the prison space, among other things, to take care of users.

What should we do on the problem of users? You have reflected on this.

Dr. KLEBER. There is clearly a spectrum when you think of users. You have a range from individuals who are so-called casual or controlled or recreational users, depending on what term you want to

describe; and then some who find they need drugs, or think they need them, to function—the advertising executive who feels he cannot do creative work without cocaine; and then finally, the addict. And I think you need different approaches to those three groups.

Senator SIMON. What I am talking about is the nonaddict user.

Dr. KLEBER. The nonaddict user, our experience tells us, responds reasonably well to sanctions. What would be useful would be a variety of sanctions: loss of driver's license; publicizing—one of the things that we don't do enough of that can shame these individuals, many of whom are employed, is to publish names in the newspapers. In some communities, that has been used with prostitution, where the names of the Johns are publicized, and apparently, that has had some effect.

What happens, unfortunately, is a number of these things get tried, and 3 months later they are dropped. People have short attention spans, and they go on to something new. We need more consistent ways of keeping the pressure on—licensing procedures, publicity, fines, workplace sanctions related to pre-employment testing, incident-driven testing—I think those can be useful for the noncompulsive user to try and bring home to that individual the consequence of his drug use.

I believe that one of the actions that has helped turn the country around on smoking was the emphasis on passive smoking. Before that, smoking was seen as an individual responsibility; you were going to kill yourself. When we came to believe that your smoking in the office where I worked, in the elevator I was in, and so, on harmed my health, people began to say I don't want you smoking in those kinds of environments.

We need to do the same with drug abuse: to get across to the casual user that what he is doing is like smoking in the same elevator that I am riding in; that his use of drugs, even though on a controlled basis, is fueling the Medellin Cartel, is creating crime on the streets, is corrupting systems of government here and abroad, and that he is responsible for that. I think that has to be a consistent message.

Senator SIMON. Thank you.

Thank you, Mr. Chairman.

The Chairman. Just a final couple of questions. Would you comment on whether waiting lists are a good measure of the shortfall in treatment availability, and what are the implications for the typical addict being placed on a waiting list.

Dr. KLEBER. I don't think waiting lists are a good indication. We have found that our waiting lists are extraordinarily elastic. That is, when we have a 1-month waiting list, people come out of the woodwork, wanting treatment. By the time the waiting list gets to 4 or 5 months, often people do not bother putting their name on a list. They hear from their friends that there is a 5-month wait, and they don't even bother to come forward.

So while waiting lists give you some indication, they are an inadequate indicator. Some programs will not bother keeping waiting lists. There is a wide discrepancy as far as how you get on a waiting list. Some programs, you have to come in person; others, you can call; some, you can write a letter. We don't even know what a

particular waiting list means without knowing exactly how it was arrived at.

Waiting lists would be the proverbial tip of the iceberg to indicate there is a problem.

The Chairman. So you believe that there are a vast number of people out there who would seek treatment if it were available.

Dr. KLEBER. I don't know about the word "vast". I think there are very substantial numbers, yes.

The Chairman. Over what is generally considered to be the numbers that are getting treatment, or a projection of the waiting list numbers; you think it is substantially beyond that.

Dr. KLEBER. Yes.

The Chairman. And could you give your assessment of what is the reaction of an individual who wants treatment and cannot get it, is told to come back in a period of time?

Dr. KLEBER. Many of them get discouraged and say the hell with it, why should I bother. We often find that disproportionately affects our minority communities. We find in our waiting list for treatment, for example, that the percentage of minority individuals who apply for treatment and get on the waiting list is smaller than the number that actually begin treatment. So the presence of waiting lists not only discourage people from signing up, but many of them, when their name does come up, are no longer available, no longer interested.

The Chairman. Last week, I visited several of the medical facilities here, primarily on the question of evaluating the outpatient treatment in terms of AIDS victims and the issue of HIV-positive and substance abuse. Drug abuse, is clearly interwoven there. And those who were involved in the program said it is increasingly difficult to get location of treatment centers. It is similar to the prison population, where everyone wants treatment, but no one wants it in their back yard.

Have you an evaluation of how much of a problem this is going to be to our country which is demanding immediate action on drugs. Since treatment is a key element, as you have very effectively testified to—how are we going to be able to address this problem?

Dr. KLEBER. That is one of the thorniest problems. I have been to probably 12 or 15 zoning board hearings, trying to get sites for our programs in New Haven. Some, we win; most, we lose.

The former First Lady was unable, even with her prestige, clout, et cetera, to get a treatment program, which was going to be a branch of Phoenix House, established in California. There was enough neighborhood opposition that she withdrew. That is going to be a major stumbling block to establishing new treatment programs.

I don't know the answer. There are some things I have thought of, but other people have told me that they are unrealistic, so I don't know, such as State override of local zoning. I have been told that is not a realistic option.

The Chairman. Well, I hope you will give us the benefit of your thoughts on that, because we are going to really have to jar the population to really think about these things in a serious way. I am uncertain about overriding State or Federal interests. But in listen-

ing to both your responses and the needs, if we are going to be serious about it, we are going to have to try and take a look at it.

We have talked about how effective treatment is for people in the criminal justice system; I think we went over that earlier, and we know it is not terribly effective in most of the Federal prisons. You mentioned its importance, and I agree that that is important.

This is a question that I would hope you might be able to submit a written response to, if you can, and that is the estimate as to how many people should be treated each year if we are to reach the goal of providing treatment to everyone who wants to cure their addiction, and how much that would cost, and how much do we need to spend on upgrading the quality of treatment. That is a pretty good afternoon's work to try and pull that together.

Dr. KLEBER. You are correct in that; I won't try and answer that off the top of my head.

The Chairman. Maybe you could submit your response in writing. I know it is difficult to get the data and the other points. But I hope we can establish some benchmarks as we start out on this so that we can begin in our own efforts to be able to support those programs that are beginning to work over a period of time. It would be very useful both in building public support and understanding.

I want to thank you very much. I found your responses very frank and compelling and informative, and I certainly look forward to supporting your nomination.

I commend the President for the selection and, importantly, getting on with the business of working closely with you.

This morning we have had Senator Hatch, who is a member of the Judiciary Committee, and Senator Thurmond, who is also a member of the Armed Services Committee. We have members on all these committees; Armed Services Committee has jurisdiction over interdiction; this committee has jurisdiction over education, prevention, research, and rehabilitation; the Judiciary Committee has the law enforcement jurisdiction with the overall interest of Senator Biden, who is really the architect of this whole effort and takes a very keen interest in and is enormously supportive of all of these efforts. So we work really closely together, and hopefully, that can make your life easier.

We admire you for taking on a tough job, and we are going to do the best that we can to make you successful.

Dr. KLEBER. Thank you very much and thank you for your attention.

The Chairman. Thank you very much.

The committee stands in recess.

[Whereupon, at 11:48 a.m., the committee was adjourned.]

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